

**Commonwealth of Massachusetts
Executive Office of Health and Human Services
Massachusetts Department of Public Health**

**BEST PRACTICE RECOMMENDATIONS
FOR HOSPITAL-BASED INTERPRETER SERVICES**

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I. BACKGROUND

Effective communication between patients and their health care providers is vital to achieving access to quality care and ensuring good health outcomes. Nowhere is this more essential than the Emergency Department, where lack of accurate, complete, and timely information can result in critical impediments to care. In recognition of this, the recently enacted Chapter 66 of the Acts of 2000 requires provision of competent interpreter services in conjunction with all emergency room and acute psychiatric services provided to non-English speaking patients in Massachusetts.

Interpretation has been defined as the conversion of "...a message uttered in a source language into an equivalent message in the target language so that the intended recipient of the message responds to it as if he or she had heard it in the original."¹

We are fortunate in Massachusetts to be on the forefront of the development and provision of interpreter services in clinical settings. While a 1995 National Public Health and Hospital Institute study found little capacity among U.S. public and teaching hospitals as a whole, Massachusetts hospitals had one of the highest concentrations of interpreter services in the region.² In addition, the Massachusetts Medical Interpreter Association has been a national pioneer in developing practice standards on the skills, behaviors, ethics, and linguistic and cultural knowledge necessary for competent interpretation.

Since 1989, most hospitals requesting permission from the Massachusetts Department of Public Health (MDPH) to transfer ownership or expand services have submitted plans for provision of interpreter services as part of the Determination of Need process.³ Through this process, over fifty hospitals have developed interpreter services, for both inpatients and outpatients. This has included designation of a coordinator of interpreter services, training for both medical interpreters and medical providers, and systems for tracking the language needs and interpreter requests of patients.

In 1996, the Massachusetts Division of Medical Assistance established an Acute Hospital Request for Application (RFA) process that developed quality measures for interpreter services. Through this quality improvement initiative, hospitals establish minimum standards of practice to ensure MassHealth members' access to trained medical interpreters at all key points of contact throughout the hospital.⁴

In April 2000, the Massachusetts Legislature enacted Chapter 66 of the Acts of 2000, "An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services,"⁵ which mandates that "every acute care hospital...shall provide competent interpreter services in connection with all emergency room services provided to every non-English speaker

¹ MMIA "Medical Interpreting Standards of Practice" page 3 available at www.mmia.org.

² Ginsberg C, Martin D, Andrulis D, et al. "Interpretation and Translation Services in Health Care: A Survey of US Public and Teaching Hospitals." Washington DC: National Public Health and Hospital Institute; 1995. Cited in Fortier JP "Multicultural Health Best Practices Overview," posted at Diversity Rx: Models and Practices, available at http://www.diversityrx.org/BEST/1_1.htm

³ Appendix 1, MDPH Determination of Need Guidelines

⁴ Appendix 2, Appendix G of the Massachusetts Division of Medical Assistance Acute Hospital RFA Guidelines

⁵ Appendix 3, Chapter 66 of the Acts of 2000

who is a patient or who seeks appropriate emergency care or treatment.”⁶ Similar requirements are made of hospitals providing acute psychiatric services.

The Massachusetts law is echoed by several federal initiatives regarding access to health and human services for limited English proficient (LEP) individuals.⁷ In August 2000, the Office for Civil Rights (OCR) for the Department of Health and Human Services (DHHS) issued an extensive Policy Guidance to providers who receive federal funds on how to comply with Title VI of the Civil Rights Act of 1964, which has been widely interpreted as ensuring equal access to health care for LEP persons.

In the same month, President Clinton issued Executive Order 13166, which mandates that each federal agency prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Lastly, in December 2000, the DHHS Office of Minority Health issued “National Standards on Culturally and Linguistically Appropriate Services in Health Care” (CLAS Standards), wherein four of the fourteen proposed standards address linguistic barriers to care.⁸

The following Best Practice Recommendations draw upon the OCR Policy Guidance, which represents over thirty-five years of the OCR’s experience working with providers to design interpreter services most appropriate for both patients and their providers.⁹ They are intended to assist acute care hospitals in developing interpreter services best suited to their particular circumstances; they are designed as a reference guide, and are not meant to supplant or expand regulations recently issued by MDPH regarding the provision of competent interpreter services in connection with emergency services.¹⁰ Please note, also, that these Best Practice Recommendations do not address the special considerations and needs in providing interpreter services for acute psychiatric care.

The Best Practice Recommendations have been developed by MDPH, in consultation with a broad array of Massachusetts organizations active in promoting the provision of competent interpreter services, including Boston Medical Center, the Boston Public Health Commission, Cambridge Health Alliance, the Massachusetts Department of Mental Health, the Massachusetts Division of Medical Assistance, Health Care for All, the Latino Health Institute, Lowell Community Health Center, the Massachusetts English Plus Coalition, the Massachusetts Hospital Association, the Massachusetts Law Reform Institute, the Massachusetts Medical Interpreters Association, the Massachusetts Office for Refugees and Immigrants, the Massachusetts Refugee and Immigrant Coalition, the Minority Health and Refugee and Immigrant Health Advisory Councils for the DPH, New England Medical Center, and the University of Massachusetts Medical School.

⁶ “Competent interpreter services” is defined in the law as interpreter services performed by a person who is fluent in English and in the language of a non-English speaker, who is trained and proficient in the skill and ethics of interpreting and who is knowledgeable about the specialized terms and concepts that needs to be interpreted for purposes of receiving emergency care or treatment.

⁷ While the law uses the term “non-English speaker” defined as “a person who cannot speak or understand, or has difficulty with speaking or understanding, the English language because the speaker primarily or only uses a spoken language other than English” the term limited English proficient (LEP) is more widely used and accepted.

⁸ CLAS Standards, also available at www.omhrc.gov/clas

⁹ DHHS OCR Policy Guidance on Title VI, also available at www.hhs.gov/ocr

¹⁰ Appendix 4, MDPH regulations on Chapter 66 of the Acts of 2000

The major purpose of this document is to identify and describe the components of an optimal interpreter services program for hospitals – both for emergency services (in compliance with the new statute) and for other hospital-based clinical services (although not for acute psychiatric care). The underlying assumption, as in the OCR Policy Guidance, is that given the differing needs and resources of each institution and the various populations and communities it serves, flexibility is important in designing a program that provides meaningful access to LEP persons. At the same time, there are a few key characteristics common to successful programs:

- The program is structured rather than ad hoc, with comprehensive written **policies and procedures**;
- The program includes regular, systematic **assessment of the language needs** of people in the service area;
- The program uses the community needs assessment and an assessment of its own resources in determining what types of oral language assistance to include in its **delivery system**;
- The program establishes specific **training and competency** protocols for both interpreters and providers; and
- The program has a **monitoring and evaluation** system in place.

II. POLICIES AND PROCEDURES

The implementation of a language assistance program is most likely to succeed where there is an organization-wide commitment to develop and staff competent interpreter services. Central to operationalizing this commitment is the development of comprehensive, written policies on language access which can guide a coordinator of interpreter services in fulfilling her/his responsibilities. These policies should be easily accessible and widely disseminated among hospital employees, and should encompass the following areas:

1. Procedures to publicize the right to and availability of free interpreter services.

- Notify LEP persons who have presented to the hospital, in their primary language, of the right to interpreter services at no charge.
- Post and maintain signage regarding the legal right to free interpreter services. Signage should be translated into the commonly encountered languages of the hospital and placed at all central points of contact, such as the emergency department, hospital entrance, admitting area, and outpatient waiting rooms.
- Publicize the availability of free interpreter services using advertisements in foreign language newspapers and other media outlets, and conduct outreach through community-based organizations.

Develop brochures, translated in the main languages of your hospital's patients, that contain a map of the hospital; a statement concerning patients' rights to an interpreter anywhere in the hospital, free of charge; and the Massachusetts Patient's Bill of Rights.¹¹

Advertise interpreter services programs in Spanish telephone directories.

2. Procedures for identifying and assessing the language needs of all patients.

- The U.S. Census 2000 format for determining whether an individual patient will require language assistance is useful for regular intake procedures because this approach has been standardized and allows for cross-referencing with census data.

This entails a two-part question: (1) "Do you speak a language other than English at home?" [Answer: "yes" or "no"] If the response is "yes", then (2) "How well do you speak English?" [Answer: "very well", "well", "not well", or "not at all"] People who answer anything other than "very well" will likely benefit from interpreter services and should have their preferred language (that in which s/he feels most comfortable in a clinical encounter) identified as part of the intake process.¹²

¹¹ Italicized suggestions represent actual examples collected from Massachusetts hospitals, for more information, contact the Office of Minority Health at MDPH, at 617-624-5270.

¹² Available at www.census.gov/dmd/www/pdf/d-61b.pdf, page 4.

- In more pressured situations, intake staff can achieve a similar assessment by asking “What language do you speak at home?” rather than a close-ended question such as “Do you speak English?” or “Do you speak Spanish?” which may result in misleading responses. Given that many patients who speak a language other than English at home are also proficient in English, follow-up questions are required to determine whether such a patient would prefer or benefit from an interpreter for medical communication.
- Massachusetts hospitals have developed a variety of innovative patient self-identification methods to facilitate access to oral language assistance, such as:

Welcome cards, printed in many different languages, instructing patients to bring the card to the information desk if they need assistance; on the reverse side are instructions in English for how to contact interpreter services.

Wallet-sized cards with the patient’s primary language written in English, as well as instructions on how to reach an interpreter for that language. Patients are able to provide this card at subsequent visits to specify their need for language assistance.

Staff badges in different languages with “I speak __ ! May I help you?” in the appropriate language; each badge is color-coded for low literacy patients. (For example, Spanish is always in purple, while Vietnamese is always in green.) Patients can then readily identify bilingual employees for assistance if they are lost or need directions.

Language identification charts can help literate LEP patients with requesting interpreter services. One such chart is organized into a “patient-visitor” column which lists the question “Do you speak __ ?” in various languages, with a matching column indicating the name of the language in English. Statistical demographic data can be used to determine which languages to include.

3. Procedures determining the staffing arrangements to be used for oral language assistance and the circumstances under which each option will be exercised. For example, for which languages, if any, staff interpreters will be hired, or for which languages, if any, contract interpreters will be called upon. [This subject is addressed in more detail in the “Delivery System” section.]
4. Procedures to guide staff in providing the appropriate type of interpreter service for every LEP patient in a timely fashion.

- An LEP patient may enter the hospital through a number of venues – by ambulance, by walking into the Emergency Department, by way of primary care or specialty clinics. Each patient encounter will likely involve contact with a variety of staff – from administrative personnel to nurses and physicians.

For hospitals which serve a large Spanish-speaking population, staff the Emergency Department with full-time Spanish interpreters who can interpret throughout the clinical encounter, from presentation to discharge. For non-Spanish-speaking LEP patients, these interpreters serve as facilitators to access the appropriate language interpreter.

- Language access is available regardless of point of entry, and is ensured across all points of contact, from presentation to discharge.

Develop patient-staff communication aid booklets, translated into different languages, to help patients and staff with basic communication – for example, “Where is the bathroom?” – while waiting for an interpreter.

Conduct daily inpatient interpreter rounds on LEP patients to assess additional patient needs and to remind clinical staff to call interpreter services as needed.

- All staff who have direct patient contact have a thorough knowledge of the available interpreter resources for both commonly and rarely encountered languages.

Orient new staff and trainees on the availability of interpreter services. Develop brochures for staff and providers on the interpreter services program and on how to schedule interpreters. Internal hospital publications can also serve as useful vehicles for reminding employees about the availability of interpreter services

5. Procedures to assure proper documentation of the LEP patient encounter.

- When a patient self-identifies as not being fluent in English, the name of the hospital interpreter and the language used to interpret is documented in the patient’s medical records.
- If a patient declines a hospital interpreter, the reason for declining the service is requested and recorded in the patient’s chart. The name of the person who interprets for the patient and her/his relationship to the patient (e.g. wife, friend, etc.) should also be recorded.

6. Procedures to provide timely and uniform telephone communication with LEP persons.

- It is important to develop systems that serve LEP patients both prior to presentation to the hospital (such as during triage and when accessing informational recordings) and following discharge (for example, when calling LEP patients regarding test results and follow-up).

Case: A Vietnamese-speaking LEP woman, receiving prenatal care at her local community hospital, calls the triage nurse in the ED speaking broken English, trying to describe some type of possible labor pains. The monolingual triage nurse determines the callback number and connects with a trained Vietnamese telephone interpreter to determine whether urgent care is needed or not.

Establish patient access lines to connect patients with an interpreter who can help them schedule or cancel an appointment, request prescription refills, and obtain information or assistance in contacting their providers.

- Institutions that have staff interpreters can use them to maximize telephone access by developing in-house telephonic interpretation systems. Dual-handset telephones, dedicated language-specific voicemail, and direct language-specific pagers can greatly facilitate communication with LEP patients.

Case: A Portuguese-speaking woman arrives at triage. She is asked to sit down while the nurse pages the Portuguese interpreter directly. Using a dual-handset telephone, where the patient holds one handset while the triage nurse holds the other, the nurse is able to assess his patient via the interpreter, who is calling from another part of the hospital. This reduces the wait time necessary for the interpreter to physically arrive at triage.

7. Procedures concerning translation of written materials.

- Translated written materials are vital – particularly documents such as patient education materials, medication labels, Massachusetts comfort care forms, consent forms, advanced directives, financial and programmatic application materials, and discharge instructions. [This is discussed in more detail under the section “Delivery Systems, Guidelines for Translation of Written Materials.”]

Develop the capacity to print discharge instructions in several different languages, which can then be tailored by an interpreter to the individual patient as needed.

- Promote adequate access to services for low literacy patients (regardless of primary language) through use of simple language, pictorial signage, and non-text-based information such as informational videotapes and audiotapes.

In order to address low literacy levels, ask interpreters to read translated documents to LEP patients. Consider audiotaping information, for example, for pre-testing or procedure instructions.

- Develop a centralized, easily accessible source for standardized, validated texts for signage and vital documents in a wide array of languages.¹³

8. Procedures ensuring ongoing, periodic training and assessment of staff at all levels, particularly those who have direct patient contact, in the concepts and practices of culturally and linguistically appropriate health care delivery. [This is addressed in more detail in the “Training and Competency” section.]

¹³ MDPH has a central clearinghouse for translated patient education materials; contact the Office of Minority Health at 617-624-5270.

9. Procedures regarding data collection.

- Develop provisions to record language preference as well as race/ethnicity data in both individual patient records and in the hospital's information systems. Additional provisions necessary to ensure that these data are consistently and accurately recorded are identified, for example, by allowing the interpreter services department to correct these entries as needed.

In many hospitals, while there is a field for patient language in the computerized patient record, it may be left blank or default to "English" if another language is not entered.

- Collect and tabulate data in a manner that permits generation of aggregate patient utilization data by preferred language and ethnicity/race.
- Track utilization data for interpreter services, including number of encounters by language and by encounter type (e.g. emergency department, surgical clinic, etc.).

10. Procedures to establish an ongoing monitoring and evaluation process.

- Develop mechanisms for annual reassessment of community language needs.
- Create systems for monitoring LEP patient satisfaction, including the accessibility and quality of interpreter services. Patient satisfaction surveys, such as those administered by the Picker Institute, can be conducted in the hospital's service area's common LEP languages.¹⁴
- Formulate and publicize grievance procedures for LEP patients in the commonly encountered languages of the hospital, including provisions for patients who feel they have not been provided with adequate interpreter services.

¹⁴ Currently, all Picker Institute survey instruments are available in Spanish, and many are available in other languages as well. Information available at <http://www.picker.org>.

III. NEEDS ASSESSMENT

A. Patient-Oriented Assessment of Language Needs

Conducting an accurate and up-to-date language needs assessment of the hospital's patient population and service area is critical to designing appropriate interpreter services.¹⁵ There are a variety of information sources that Massachusetts hospitals can consult to identify the languages most likely to be encountered, including, but not limited to:

1. Hospital utilization data of the primary/preferred languages of patients using the hospital. [Note: Data may be limited because institutions may not have previously collected this information, or collected it in a way that is not readily accessible.]
2. Input from a community advisory board, consultants and key informants from community-based organizations, and/or community meetings. Massachusetts Mutual Assistance Associations, self-help agencies for newcomer communities, can provide useful information on the most recently arrived populations. (Contacts available at www.state.ma.us/dph/orih/apri99.htm.)
3. General information from the Massachusetts Immigrant and Refugee Advocacy Coalition (MIRA), a statewide coalition of grassroots immigrant organizations. MIRA's publication "Health Care Access for Immigrants and Refugees" is a valuable resource for hospitals. (Information available at www.miracoalition.org.)
4. "Primary Language Is Not English" (PLINE) surveys of the public school system generated annually by the Department of Education and compiled by the MDPH Office for Refugee and Immigrant Health. (Survey available at www.state.ma.us/dph/orih.)
5. Information collected by municipal Boards of Health. (A list of Massachusetts' local Boards of Health is included in the appendices.¹⁶)
6. Massachusetts Division of Medical Assistance data on self-reported, preferred, spoken and written language preferences of MassHealth Benefit Request/Children's Medical Security Plan applicants. (This information will be available Fall 2001, at www.state.ma.us/dma.)
7. Data from the Massachusetts Department of Public Health, including the Massachusetts Community Health Information Profile (MassCHIP) and a broader array of publications which include ethnic/racial group data and special reports on specific ethnic/racial groups. (MassCHIP available at <http://masschip.state.ma.us> other publications available at www.state.ma.us/dph/pubstats/htm.)
8. U.S. Census data of the hospital's service area. (Available at www.census.gov.)

¹⁵ The OCR Policy Guidance describes "service area" as the geographic area that has been approved by a Federal grant agency; where no service area has been approved, the relevant service area will be considered "as that designated and/or approved by state or local authorities or designated by the [hospital] itself, provided that these designations do not themselves discriminatorily exclude certain populations."

¹⁶ Appendix 5, Massachusetts Local Boards of Health Addresses

While hospital utilization data may be useful in determining which languages are spoken by patients, routine assessment of the needs of the entire surrounding area can be very instructive. People may reside in the geographic service area of an institution but utilize a farther, less convenient hospital because of established community linkages with another hospital or a historical lack of language services at the local institution. In these situations, community input can play a particularly pivotal role in orienting institutions to the needs of their service area.

The Health Access Collaborative is a coalition of community-based groups, hospitals, and community health centers in Fall River and New Bedford, established to increase the number and quality of medical interpreters in all locations where LEP persons seek health and related services. The initiative focuses on the needs, roles and interactions of each and every component of the local delivery system.

Consideration of other important variables that can amplify or exacerbate access barriers that LEP persons face (e.g. race/ethnicity, gender, socioeconomic status, and insurance status) can also be a helpful component of the needs assessment process. The Bureau of Health Statistics, Research and Evaluation at MDPH is available for consultation to ensure compatibility with its race/ethnic identifiers and OMB 15 compliance.

B. Internal Assessment of Institutional Needs

A counterpart to the community needs assessment process is institutional assessment of existing practices, systems, and resources for interpreter services in order to identify areas in need of improvement.¹⁷ This process should include an assessment of the following:

1. What are the hospital's current practices and resources for interpretation and translation?
 - How are LEP patients currently being identified?
 - Who is currently being used to interpret, under what conditions, and how often?
 - What process currently exists to document patient language and race/ethnicity?
 - What types of information are being translated, into which languages, and by whom?
2. Where in the hospital are interpreter services needed?
 - Where are the points of patient contact, from presentation to discharge, where language assistance will likely be needed?
3. What types of interpreter services, at what frequency, are needed to serve the hospital's patient population? [Please see the "Delivery System" section for specific suggestions.]
 - Which positions (for example, receptionists, triage, providers) would be best served by using bilingual staff, and for which languages?
4. What additional resources will be needed to address gaps between current practices and newly identified needs ?
 - What resources are currently available in the local community?
 - What resources will need to be developed internally?
5. What specific steps need to be taken to best obtain and utilize these additional resources?

¹⁷ The National Council on Interpretation in Health Care is developing a needs assessment evaluation tool for health care organizations which will be available later this year at www.ncihc.org.

IV. DELIVERY SYSTEM

The specifics of each hospital's interpreter services delivery system will necessarily vary, given the diversity of institutions and their surrounding communities. Factors that may influence a site-specific design include the size of the hospital, the size of the LEP population it serves, the total resources available to the hospital, and the frequency with which particular languages are encountered. The OCR Policy Guidance emphasizes that there is no "one size fits all" approach to designing interpreter services, and that the focus should be on the end result – whether LEP individuals have meaningful, equitable access to the hospitals' services.

For all hospitals, there are four core components to building an optimal interpreter services delivery system:

- Designation of a coordinator of interpreter services to oversee the implementation, training, and monitoring aspects of the program;
- Development of a scheduling and tracking system for interpreters;
- Determination of what types of oral language assistance are best for a given hospital and its patients; and
- Establishment of policies, standards, and procedures for translating written materials.

A. Coordinator and Administrative Structure

Designation of a director or coordinator of interpreter services can increase programmatic coordination by centralizing responsibility for the following:

1. Development, promulgation, and updating of institutional policies and procedures for the provision of interpreter services and translation of written materials.
2. Implementation of an annual language needs assessments of the hospital's service area.
3. Training, supervision, management, and support of interpreters and training of staff/providers who will be working with interpreters. This may entail development of an on-site training program or participation in an existing program. Interpreters' skills also need to be assessed on a regular basis.
4. Development and implementation of a system for timely provision of interpreter services, including a scheduling system for appointments where the need for an interpreter is anticipated, as well as for those visits that are not scheduled (e.g. Emergency Department or inpatient services).
5. Integration of monitoring and evaluation processes for interpreter services into institutional quality assurance measures and risk management programs, including grievance procedures for individual patients.

Depending on the size and needs of the LEP population, some hospitals may require several full-time staff to optimally cover all aspects of interpreter services, while others may not require even an entire full-time equivalent.

B. Scheduling and Tracking System

When a patient's need for oral language assistance can be anticipated, coordination of interpreter services with scheduled appointments can be greatly facilitated by integrating scheduling of interpreter services into the general scheduling and appointment system. Although many hospitals have developed computer-based information systems, their potential to track requests, scheduling, and utilization of interpreter services has largely been unrealized. Such computerized systems can facilitate language needs assessment by recording patient language characteristics, assist in determining reimbursement rates by tracking utilization of interpreter services, and streamline patient care by reducing wait times for interpreter services. Lack of coordination between scheduling clinician visits and interpreter services can lead to unnecessary delays, interruptions, and frustration for clinicians, patients, and interpreters alike.

Several hospitals have computerized systems that allow scheduling of provider and interpreter appointments simultaneously.

When possible, scheduling the same medical interpreter for a patient's return visits provides added continuity of care. Concordance of gender or national origin between the interpreter and patient may be important for some patients or some clinical encounters as well.

For patients for whom oral language assistance has not been anticipated, either because their visit is unscheduled (as in the Emergency Room) or because their level of English proficiency is unexpectedly found to be insufficient for effective, direct communication, the interpreter services scheduling system should be able to provide interpretation in a timely manner. Clearly, this is easiest for those languages for which the hospital has staff interpreters on site. However, in some areas, there are community-based organizations which assure the arrival of a trained interpreter within a specified period of time.

There are numerous agencies in Massachusetts which contract with institutions to provide trained interpreters for different languages. The interpreter is typically expected to arrive within 30 minutes of the hospital's request.

C. Models of Oral Language Assistance and Recommendations for Use

No single model of oral language assistance can be recommended for all hospitals; indeed, most hospitals will find that to best serve their patients, they need to use a combination of the models described below. However, there are three common characteristics of best practice interpreter services systems:

- 24-hour access to oral language assistance for all LEP patients;
- Timely delivery of interpreter services for all languages; and
- Uniform training and evaluation of competency across the various types of oral language assistance used (this is discussed in more detail in the “Competency and Standards” section).

The following represent six common components of hospital-based interpreter services.

Staff Interpreters	Professional interpreters who are hired as full-time or part-time regular employees of the hospital. Some professional interpreters are able to provide interpretation for more than one non-English language. Paid staff interpreters are particularly appropriate when there is a frequent and/or regular need for a specific language.	
Contract Interpreters	Professional interpreters who are not regular employees of the hospital. They can be hired as <i>per diem</i> , on-call adjuncts to supplement in-house capabilities as needed, or as freelance interpreters on an hourly basis. Freelance interpreters are generally paid a minimum of two hours per hospital visit, even if the visit requires less time. Contract interpreters are typically used when demand for a given non-English language is intermittent or infrequent, or when a hospital has less common LEP language groups in its service area.	
Employee Language Banks	Pools of hospital employees whose work responsibilities may not include direct patient contact, but who have been formally identified as speaking languages other than English and can be called upon to interpret when needed. Employee language banks work best when they maintain updated lists of eligible employees, assess employee language and interpretation skills, provide interpreter training, and include interpretation as a listed job duty.	Caution should be exercised in utilizing employee language banks. Hospitals that use employee language banks often fail to provide the training and assessment of language skills necessary to ensure quality interpretation. Furthermore, without explicit inclusion of interpretation in their job descriptions, employees may experience job conflicts when they are called away from their regular duties to interpret. This is an unfair burden on the employee, and may lead to tension between the employee and her/his supervisor or colleagues.

Community Interpreter Banks	Community-based agencies that contract with institutions to provide trained interpreters in a wide range of languages. While available only in a limited number of geographic areas, they can serve as a shared resource that allows many institutions to access interpreters, especially from small populations, when hiring them individually would be cumbersome. There are several community interpreter agencies in Massachusetts. ¹⁸	
Telephonic Services (also known as “remote consecutive interpretation”)	These services provide an interpreter who is accessed over a telephone line, often by speakerphone. Telephonic services are most appropriately used when an on-site interpreter is unavailable, especially when an interpreter is needed rapidly, or when interpretation is needed for an unusual or rarely encountered language. Telephonic services should be used as interpreters of last resort.	There are several national telephonic services which provide interpretation 365 days a year, 24 hours a day. ¹⁹ Prior to contracting with such a service, it is advisable to establish what type of training is provided to its interpreters, particularly in terms of medical concepts and terminology. Developing in-house telephonic services with existing staff interpreters can be more cost-effective and efficient than using an outside agency.
Remote Simultaneous Interpretation	A relatively new modality where the patient and provider communicate using wireless remote headsets. The interpreter, who is trained in the skills of simultaneous interpretation commonly used at international conferences, is located in a separate room (or separate building) and provides simultaneous interpreting services to the patient and provider. Given the technologic infrastructure required, it is not surprising that only a few centers across the country have been able to develop such a program. However, if facilities are properly equipped, such a program enables an interpreter to serve multiple health care facilities simultaneously.	

Key Issue: Bilingual and Multilingual Staff/Providers

For hospitals that serve many LEP patients who speak the same language, the use of bilingual or multilingual staff/providers who can communicate directly with these patients is not only more efficient, but also may better support the patient-provider relationship. Volume permitting, hospitals may consider organizing outpatient clinics around patients’ language needs by staffing the clinic with receptionists, nurses, aides, and providers who are fluent in both English and the needed language. An additional benefit of bilingual staff/providers is that they may share similar cultural backgrounds with many of the institution’s LEP patients, and may therefore be able to minimize cross-cultural miscommunication.

While many hospitals have made an effort to hire bilingual or multilingual staff/providers, few have attempted to evaluate them in a standardized manner. Self-identification as bilingual is not

¹⁸ Appendix 6, Massachusetts Community Interpreter Banks

¹⁹ Appendix 7, List of organizations that provide telephonic services

sufficient to ensure good communication, and needs to be confirmed by formal assessment. Additionally, if these bilingual staff will be called upon to interpret for other providers, they should also receive training and assessment of interpreting skills. Some hospitals in California augment the salary of providers who pass oral examinations for languages that are needed to serve their patient populations.

Where there are a variety of non-English languages in a hospital's service area, using bilingual staff alone is unlikely to be sufficient to meet the needs of all LEP patients, and should be supplemented with other types of oral language assistance.

Key Issue: Cost

Not all interpreter services cost the same. For hospitals with a high volume of patients who speak a certain language, it may be more cost effective to hire a staff interpreter (who can interpret many patient encounters a day) rather than freelance interpreters who charge a minimum number of hours per encounter. Freelance interpreters in Massachusetts currently charge between \$15 and \$45 an hour, depending on the local market, their skill level, and the language involved. Staff interpreters in Massachusetts hospitals are generally paid between \$12 and \$20 an hour, plus benefits.²⁰ Telephone interpreting, if used frequently, can be very expensive. (One company's rates vary between \$2.20 and \$7.25 per minute, depending on whether the caller has a subscription, the time of day, and the language required.²¹)

Key Issue: Use of Family and Friends

The OCR Policy Guidance states that a hospital that receives federal funds “may expose itself to liability under Title VI if it requires, suggests, or encourages an LEP person to use friends, minor children, or family members as interpreters, as this could compromise the effectiveness of the service. Use of such persons could result in a breach of confidentiality or reluctance on the part of individuals to reveal personal information critical to their situations.”

Case: A married couple presents to the Emergency Department because the woman has fallen and hurt her leg. When the interpreter introduces herself to the patient, the man answers for her, and adds that his wife doesn't need an interpreter, because he always interprets for her. He states further that he can remember her medical history better than she can herself. The interpreter explains that medical interpreters are specially trained to help patients and providers communicate about health problems. In addition, she informs the couple that it is hospital policy for patients to speak alone with their provider for at least part of the visit. When the patient is called in, she is accompanied by the medical interpreter. With gentle questioning by the doctor, the patient reports that she arrived in the U.S. a little over a year ago. She has been isolated and doesn't have any family here. Her husband won't allow her to call home, saying it is too expensive. She says she and her husband have fights and sometime she falls during the fights... with supportive questioning, the woman shares more. The doctor provides emotional support to the woman (says the injuries are not her fault and that no one deserves to be treated in such a way) and gives the woman referrals to agencies and resources, including the Massachusetts statewide domestic violence hotline number [1-877-785-2020]. The doctor then asks the woman if she would like to call the hotline right now.

²⁰ Loretta Saint-Louis MA legislative testimony, 2/23/01

²¹ Rates according to promotional materials, as of 4/01/01.

As a rule, minor children should not be used as interpreters, even for parents. While this does not imply that parents cannot have their children accompany them throughout the clinical encounter, there are clearly varying levels of appropriateness. An encounter where a nine-year-old is expected to interpret symptoms of rectal bleeding for his mother is quite different from one where a seventeen-year-old who has a sore throat is asked to interpret her father's questions about antibiotics. However, a trained interpreter should be available for both encounters.

If an LEP person explicitly declines the offer of interpreter services and requests a friend or family member to be her/his interpreter, the hospital needs to first ensure that the patient understands that interpreter services are legally guaranteed and free of charge, and ask permission to have a trained interpreter sit in on the encounter to ensure accurate interpretation. If the person continues to request that a friend or family member interpret, the OCR Policy Guidance states that the hospital may proceed, provided that the use of such a person does not compromise the effectiveness or confidentiality of the patient, and provided that the offer and the patient's wishes are documented in the patient's file. Some institutions have created a formal waiver form, written in the patient's preferred language, to be signed by both patient and provider.²²

²² Oregon Health Sciences University, Maria Michalczyk

D. Guidelines for Translation of Written Materials

Translation is often confused with interpretation. It is important to understand that these are different activities requiring separate skill sets. Translation is the conversion of written text from one language into another, while interpretation involves the spoken word. Properly translated written materials can be critical to ensuring effective communication in the medical setting such as in the case of obtaining informed consent, establishing advanced directives, and issuing discharge instructions and prescriptions.

Clearly identifying the target audience is the first and most important step in developing an effective translation. This decision involves determining the literacy level, the cultural concepts, and the regional language variations that are to be incorporated into the translation.

The goals of translation include assuring reliability, completeness, accuracy, and cultural appropriateness. Reliability is achieved when the meaning of the original text is clearly conveyed in the new language. Completeness is achieved when nothing is omitted and nothing is added to the original message. Accuracy is achieved when a text is free of spelling and grammatical errors. Cultural appropriateness is achieved when the message of the text is meaningful and appropriate for the target culture.

The MDPH publishes “Translation Procedure for Written Materials” which recommends a non-literal translation of material in order to convey the desired message in a more culturally relevant way than the use of a verbatim or word-for-word translation.²³ Its procedure involves two translators: one to perform the initial translation, and a second, independent translator to review and edit the translation for completeness, accuracy, and appropriateness. This two-step process reduces the risk of errors, and increases the likelihood that diversity within a culture will be adequately represented.

An additional step of “back translation” can assure that the message has been received as intended. This entails a third translator who reads the translated document and translates it back into the original language. Whether or not back translation is performed, consensus reconciliation, where both or all three translators discuss and agree on the final wording, can produce translations that are maximally accessible to the intended audience. Ideally, after translation has been completed, the document should be field tested for content, graphics, and literacy level in the target population prior to wide dissemination.

Qualifications of translators should include formal education in the target language (with demonstrated ability to read and write), ability to read and write in the source language, knowledge and experience with the culture of the intended audience, and relevant health background.

Given the time and expertise required for professional translation, most hospitals have not internally staffed and budgeted for translation services. However, given their experience, hospital interpreters can provide valuable input regarding what types of information should be prioritized for translation. Massachusetts has a statewide pool of translators that can be accessed through the state government’s Operational Services Division.²⁴ There are also organizations that provide translation services. Charges may vary, depending on the language required.²⁵

²³ Appendix 8, MDPH Translation Procedure for Written Materials

²⁴ Contact Operational Services Division at 617-720-3381 for its list of translators.

²⁵ Appendix 9, List of organizations that provide translation services

The OCR Policy Guidance suggests that officially translated vital documents be provided for LEP groups that “constitute 5% or 1000, whichever is less, of the population of persons eligible to be served or likely to be directly affected.” Even for populations consisting of fewer than 100 LEP persons, the Policy Guidance recommends providing written notice in the primary language of the right to receive competent sight translation of written materials. Regardless of numeric thresholds, the clinical circumstances of a particular LEP patient may necessitate written translation of certain materials, such as prescription, discharge, or follow-up instructions, to ensure quality care.

Web-Based Resources

Given the effort required for high quality translations, the development of clearinghouses for translated materials can clearly result in savings, both in terms of labor and costs. This can be difficult when each department or division within a hospital maintains its own documents such as customized consent forms. Another issue that may arise, particularly with health education materials, is that hospitals may require that the same message be delivered in English and other languages, which makes it more difficult to “borrow” or use pre-developed materials from other organizations.

Despite these obstacles, there are ongoing efforts to use computer-based databases, clearinghouses, and linkages to maximize and share resources. Some institutions, such as Oregon Health Sciences University, have developed intranet-based libraries for its providers to access electronically.²⁶ Other organizations compile linkages to other sites with translated medical materials. For example, the New Mexico Refugee and Immigrant Health Program has compiled linkages for 17 different languages in 6 broad subject areas (TB, hepatitis, immunizations, STDs, nutrition, and general forms).²⁷ While such sites can provide a wealth of information, there continue to be problems with being able to update linkages which change, and more importantly, with issues of quality and standardization.

The development of state, regional, or national clearinghouses for standardized, high quality medical translations would require the efforts of many different organizations and individuals, but would be well worth the effort. One such regional model is the Multilingual Health Education Net (MLHEN) based in British Columbia, Canada.²⁸ MLHEN serves as a clearinghouse for translated health education materials for approximately 25 different hospitals and nonprofit health care organizations. Member organizations are responsible for the original translations, which are then screened by MLHEN before being posted on the website. The literacy level of English text to be translated is at the 6th grade level or lower, and each translation is subjected to community and medical vetting, and assessed for accuracy and appropriateness.

Short of such a rigorous process, interim steps to standardize existing resources include consistently specifying the target audience and describing how the process used for translation (e.g. use of simple translation, two step translation-editing, back translation, or field testing).

²⁶ Available at <http://www.ohsu.edu/interpreters/interpreter.html>.

²⁷ Available at <http://star.nm.org/refugee/resources/foreign/index.htm>

²⁸ Available at <http://www.multilingual-health-education.net/#top>.

V. TRAINING AND COMPETENCY

The best way to ensure competent interpretation is through standardized interpreter training and evaluation. This will help minimize the risk of error that may occur with ad hoc interpretation, such as deletions, additions, inaccuracies, misrepresentations and distortions of the intended message, which can be complicated by the fact that neither the patient nor the provider is able to judge the quality of interpretation. Competent interpreter services can help avoid unneeded testing, misdiagnosis, and inappropriate treatment for the patient, liability for the provider, and increase access to care, patient satisfaction, and patient follow-up. The OCR Policy Guidance recommends that all interpreters – whether paid or volunteer, professional interpreters or bilingual staff/providers/employees – be trained and competent to interpret.

There are three major target audiences for interpreter service training:

- Paid or volunteer interpreters whose primary responsibility in the hospital setting is interpretation;
- Employee language bank interpreters and bilingual staff/providers who can communicate with LEP patients without the assistance of an interpreter but whose primary hospital responsibilities do not include interpretation; and
- Staff/providers with direct patient care responsibilities who require the assistance of interpreters to communicate with LEP patients.

A. Interpreter Training

Depending on a hospital's needs and resources, interpreter training may be provided internally by the institution or externally by a qualified outside program. The newly enacted Massachusetts' law (Chapter 66 of the Acts of 2000) requires training for interpreters working in acute care hospital emergency departments, and best practice suggests that training be provided for all types of medical interpreters including staff interpreters, contract interpreters, bilingual staff, members of employee language banks, community bank interpreters, telephonic interpreters and remote simultaneous interpreters. For bilingual staff/providers and employee language bank interpreters, whose primary work responsibilities do not include interpretation, compensated time for training is considered a best practice.

Continuing education is also an important aspect of interpreter training and professional development, and can be assured by including provisions for ongoing training in hospital interpreter job descriptions or contracts. Similarly, adequate supervision and support for interpreters is central to a sustainable interpreter services program.

In the fall of 2000, Massachusetts' Health Care for All ER Interpreter Law Working Group compiled a list of medical interpreter training programs in Massachusetts – eight formal training programs covering a variety of languages.²⁹ Most are designed to prepare interested, bilingual individuals to serve as medical interpreters, although some also target bilingual medical staff and providers. All programs assess bilingual proficiency prior to enrollment, and one requires previous coursework.

²⁹ Appendix 10, Health Care for All ERIL Working Group "Medical Interpreter Trainings – Massachusetts"

Basic training program content includes the role of the medical interpreter, interpreting skills, awareness of biomedical culture, cross-cultural communication, ethics of interpreting, standards of professionalism, and medical terminology. While interpreter training programs vary considerably in their length, some experts in the field feel that 40 hours may represent a reasonable minimum length of initial training.³⁰

- Since 1998, the MassHealth Access Program has offered two statewide training programs: a Comprehensive Training Program of 54 hours, and an Introductory Training Program of 15 hours. The training program's goal is to increase the capacity of health care providers to meet the needs of limited English speaking MassHealth consumers by providing medical interpreter training to acute care hospitals, community health centers, independent group practices, nursing homes, and visiting nurse associations contracted with DMA to serve MassHealth members throughout the Commonwealth. The introductory program was developed to provide a more flexible program in order to maximize provider participation. The comprehensive program builds on the interpreter skills acquired in the 15-hour session, with a particular emphasis on issues of cultural competence.
- Since the passage of Chapter 66 of the Acts of 2000, the MDPH's Office of Refugee and Immigrant Health has funded the Massachusetts Medical Interpreter Association (MMIA) to develop an advanced training program consisting of 20 three hour sessions. Each session involves role playing and discussion of a case scenario involving one of the 20 most prevalent diagnoses encountered in large city emergency rooms and mental health centers.³¹
- The MMIA is also licensed to teach "Bridging the Gap," a 40-hour basic/intermediate training course developed by the Cross Cultural Health Care Program (CCHCP) in Washington state. Agencies and institutions in Massachusetts can also contract directly with CCHCP to provide a course entitled "Training the Trainers for Bridging the Gap".³² A 1997 directory of U.S. and Canadian medical interpreter training programs is included in the appendices.³³

B. Staff/Provider Training

Hospitals may develop effective policies and procedures around language assistance, but if employees are unaware of the policies, equal access for LEP patients will not be achieved. In addition to widespread dissemination of these policies, hospitals need to consider how to provide training to staff and providers who work with interpreters. In order for interpreters to function optimally in the hospital environment, staff and providers who work with interpreters need to have clear expectations of their respective roles and responsibilities.

Given the time constraints of hospital staff and providers, integrating training on interpreter services into existing educational and administrative structures is effective and efficient. Attendance is highest, and training is most effective, when this material is incorporated into settings such as employee orientation, nurse orientation, staff meetings, in-services, risk

³⁰ Fortier JP "Multicultural Health Best Practices Overview", posted at Diversity Rx: Models and Practices, available at http://www.diversityrx.org/BEST/1_3.htm#131.

³¹ Information available at <http://www.MMIA.org>.

³² Information available at <http://www.xculture.org/training/overview/interpreter/programs.html>.

³³ "Directory of Health Care Interpreter Training Programs in the United States and Canada", available at <http://www.ahschc.org/profiles5-98.pdf>.

management sessions, medical school seminars, grand rounds, and continuing medical education programs.

Optimal training includes such topics as:

- The impact of language barriers on patient care;
- When and how to call for an interpreter;
- How to work with on-site and telephone interpreters;
- Problems with using friends and family members as interpreters;
- The dynamics of the triadic relationship (patient – interpreter – staff/provider);
- Ethical and legal issues; and
- Negotiation of cultural issues in health and communication.

Effective teaching and learning methods include: didactic lectures incorporating relevant data on the consequences of language barriers and the effectiveness of interpreter services; videotape materials; and role playing. It is important that training be appropriately customized to the target group, both in terms of content focus and time constraints – case studies and role plays should be attuned to the participants’ field (nursing, medical specialty) as well as to their level of expertise (students, house staff, attendings, etc.).

A limited number of curricula developed for medical staff and providers exist and include lectures, videotapes, and role-plays.³⁴ There is a need for further development of such training programs, particularly those that emphasize provider-interpreter cross-training. It is important to supplement such training with information on hospital-specific policies and procedures.

C. Competency Assessment

While it is widely accepted that competency assessment is an important element of interpreter services, no universally accepted definitions or standards of medical interpreter practice exist. However, in 1998, the National Council on Interpretation in Health Care endorsed the MMIA’s 1996 publication “Medical Interpreting Standards of Practice”³⁵ as “the best statement of standards for medical interpreters presently available.” This section draws upon the MMIA Standards which have been designed with several possible uses in mind, including evaluation of individual interpreters.

Evaluation and assessment are essential components of ensuring quality in health care service delivery. Competency does not necessarily mean formal certification as an interpreter; however, all types of medical interpreters should be assessed for competency, including staff interpreters, contract interpreters, bilingual staff, members of employee language banks, community bank interpreters, telephonic interpreters and remote simultaneous interpreters. When deciding which telephonic service to use, it is important to first determine the extent and content of training that

³⁴ Please see “Resources” section for more details.

³⁵ MMIA “Medical Interpreting Standards of Practice” available at www.mmia.org.

has been provided to the interpreters. Quality control can then be provided by performing random, periodic checks of telephonic service competency, using assessment tools that have been developed specifically for this purpose.

The MMIA differentiates between two sets of skills: linguistic proficiency and interpreting skills. This distinction is made in order to set standards of excellence for accuracy and completeness of interpretation while acknowledging the urgent need for interpreters in languages for which there are insufficient numbers of individuals proficient in both the needed language and English. Thus, there may be interpreters who are somewhat limited in their comprehension and depth of expression, but who can ensure accuracy and completeness in their interpretations by maintaining an awareness of their personal limitations and asking for clarification as needed. With this said, fluency in English and the languages to be used for interpreting is generally deemed necessary, but not sufficient, to produce high quality interpretation.

Many hospitals have designed their own instruments to evaluate interpreter competency, leading to variability in expectations and practices across institutions. However, some hospitals have begun regional collaborations to develop uniform measures of functional performance for medical interpreters. Creation of such “competency networks” with shared standards allows for reciprocity, and avoids duplication of evaluation efforts, particularly for uncommon languages for which there may only be a few interpreters available in a given region.

With appropriate modifications for different types of interpreters (for example, the triadic relationship is not relevant for bilingual staff/provider encounters, and physical and spatial cues are not issues for telephonic or remote simultaneous interpretation), the MMIA Standards can serve as a useful reference for measuring the three major areas of competency: skills, knowledge, and understanding of ethics. Some Massachusetts hospitals have already adapted the MMIA Standards into an evaluation tool used for periodic audits of their interpreters’ oral skills. The following outline is intended as an overview of each of the three areas, and is not meant to be comprehensive or exhaustive in scope.

1. Core Skills

- Proficiency in English and the languages to be used for interpreting.
- Capability to interpret from and into each language pair that is being interpreted.
- Ability to interpret a message uttered in a source language into an equivalent message in the target language so that the recipient responds to it as if s/he had heard it in the original language; key measures of such interpretation are accuracy and completeness.
- Capacity to manage the flow of communication between patient and staff/provider. (This includes attention to interpersonal dynamics between patient and staff/provider, as well as managing the triadic relationship so that the patient and staff/provider relate primarily to each other.)
- Ability to serve as cultural broker, if necessary, between patient and staff/provider. (This involves sensing if and when culturally based beliefs are affecting the perception and presentation of illness, as well as being able to articulate these cultural differences or practices to staff/providers and patients.)

2. Core Knowledge

- Comprehension of medical terminology and concepts in English and all languages to be used for interpreting. Depending on the clinical circumstance, additional specialized training may be required on the concepts, terminology, and psychosocial issues around a specific area (for example, rape counseling, child abuse assessment, psychiatric encounters, and bereavement interventions).
- Familiarity with common, relevant socio-cultural assumptions and circumstances that may impact the staff/provider-patient interaction. This includes knowledge of specific cultural concepts as well as an understanding of biomedical culture.
- Understanding of “untranslatable words”, which represent source language concepts for which a comparable referent does not exist in the society of the target language.

3. Code of Ethics

A number of organizations have generated medical interpreter codes of ethics. All are designed to address the tensions between being a member of a community and being a medical professional. All are designed to avoid potential abuses of power when the interpreter is the only one involved in the medical encounter who understands both languages.

The following code was formulated by CCHCP, and represents a “combination of the Codes of Ethics from the Hospital Interpretation Program in Seattle, WA; Boston City Hospital [*sic*] in Boston, MA; and the American Medical Interpreters and Translators Association (AMITAS) in Stanford, CA.”³⁶ The MMIA also has a Medical Interpreter Code of Ethics.³⁷

- Confidentiality
Interpreters must treat all information learned during the interpretation as confidential, divulging nothing without the full approval of the client and her/his provider. [This should be relayed to the patient as well, in order to assure her/him it is safe to divulge private or sensitive information.]
- Accuracy: Conveying the Content and Spirit of What is Said
Interpreters must transmit the message in a thorough and faithful manner, giving consideration to linguistic variations in both languages and conveying the tone and spirit of the original message. A word-for-word interpretation may not convey the intended idea. The interpreter must determine the relevant concept and say it in language that is readily understandable and culturally appropriate to the listener. In addition, the interpreter will make every effort to assure that the client has understood questions, instructions and other information transmitted by the service provider.
- Completeness: Conveying Everything that is Said
Interpreters must interpret everything that is said by all people in the interaction, without omitting, adding, condensing or changing anything. If the content to be interpreted might be perceived as offensive, insensitive or otherwise harmful to the dignity and well-being

³⁶ CCHCP, available at <http://www.xculture.org/interpreter/overview/ethics.html>.

³⁷ Appendix 11, MMIA Interpreter Code of Ethics and available at www.mmia.org.

of the patient, the interpreter should advise the health professional of this before interpreting.

- **Conveying Cultural Frameworks**
Interpreters shall explain cultural differences or practices to health care providers and clients when appropriate.
- **Non-Judgmental Attitude about the Content to be Interpreted**
An interpreter's function is to facilitate communication. Interpreters are not responsible for what is said by anyone for whom they are interpreting. Even if the interpreter disagrees with what is said, thinks it is wrong, a lie or even immoral, the interpreter must suspend judgement, make no comment, and interpret everything accurately.
- **Client Self-Determination**
The interpreter may be asked by the client for his or her opinion. When this happens, the interpreter may provide or restate information that will assist the client in making his or her own decision. The interpreter will not influence the opinion of patients or clients by telling them what action to take.
- **Attitude Toward Clients**
The interpreter should strive to develop a relationship of trust and respect at all times with the client by adopting a caring, attentive, yet discreet and impartial attitude toward the patient, toward his or her questions, concerns and needs. The interpreter shall treat each patient equally with dignity and respect regardless of race, color, gender, religion, nationality, political persuasion or life-style choice.
- **Acceptance of Assignments**
If level of competency or personal sentiments make it difficult to abide by any of the above conditions, the interpreter shall decline or withdraw from the assignment. Interpreters should disclose any real or perceived conflict of interest that could affect their objectivity. For example, interpreters should refrain from providing services to family members or close personal friends except in emergencies. In personal relationships, it is difficult to remain unbiased or non-judgmental. In emergency situations, interpreters may be asked to do interpretations for which they are not qualified. The interpreter may consent only as long as all parties understand the limitations and no other interpreter is available.
- **Compensation**
The fee agreed upon by the agency and the interpreter is the only compensation that the interpreter may accept. Interpreters will not accept additional money, considerations or favors for services reimbursed by the contracting agency. Interpreters will not use the agency's time, facilities, equipment or supplies for private gain, nor will they use their positions to secure privileges or exemptions.
- **Self-Evaluation**
Interpreters shall represent their certification(s), training and experience accurately and completely.
- **Ethical Violations**
Interpreters shall withdraw immediately from encounters that they perceive to be in violation of the Code of Ethics..

- Professionalism

Interpreters shall be punctual, prepared and dressed in an appropriate manner. The trained interpreter is a professional who maintains professional behavior at all times while assisting clients and who seeks to further his or her knowledge and skills through continuing studies and training.

Beyond the initial assessment that establishes a person as competent to serve as a medical interpreter, the hospital should establish a mechanism for ensuring periodic reassessment of skills, knowledge, and understanding of ethics.

VI. MONITORING AND EVALUATION

Effective systems require ongoing monitoring and periodic evaluation that includes input from their primary stakeholders. On the individual level, this includes LEP patients, providers/staff, and interpreters themselves. On an institutional level, this includes hospital administration and the LEP communities which use the hospital. Community input is important, not only in conducting annual language needs assessments, but in assisting the hospital in designing an interpreter services that truly improves the LEP patient's experience of care.

One way to obtain information is to establish and encourage a "comments and complaints" process which is widely publicized and closely monitored. For patients, this includes developing a formal grievance procedure. Periodic assessment of patient satisfaction regarding the accessibility and quality of their hospital experiences, including interpreter services, should be conducted in the major non-English languages of the service area. Eventually, these measures may be incorporated into statewide surveys of patient satisfaction.

Among hospital employees, feedback from both users (staff/providers) and providers (interpreters) of interpreter services should be formally solicited. Measurement tools should gauge important process measures of the system, such as knowledge of existing policies and procedures, ease of accessing interpreter services, interpreter response time, cancellation rates, and simplicity of documentation and required paperwork. Satisfaction with the interpreter encounter should be explored as well, from both staff/provider and interpreter perspectives. The MMIA "Medical Interpreting Standards of Practice" can serve as a useful guide in this arena.³⁸

Hospital evaluation of interpreter services depends heavily on the data systems available to collect and analyze information on patient language and patient utilization of hospital services, including interpreter services. Periodic chart reviews can assist in assessing the completeness and accuracy of data collection. Such data can be invaluable in assessing both the financial and quality of care impact of interpreter services; for example, whether increased utilization of interpreter services leads to decreased return ER visits, decreased medication errors, increased patient compliance, and improved health status.

³⁸ MMIA Medical Interpreting Standards of Practice available at www.mmia.org.

VII. ADDITIONAL RESOURCES

With the passage of Chapter 66 of the Acts of 2000, many Massachusetts hospitals will be searching for new ideas and resources to establish, expand, or improve their interpreter services. Organizations such as the Massachusetts Medical Interpreter's Association [www.mmia.org] and Washington state's Cross Cultural Health Care Program (CCHCP) [www.xculture.org], can provide general information and resources on interpreter services. The Department of Health and Human Services Office of Civil Rights is committed to providing technical assistance in this area [www.os.dhhs.gov/ocr].³⁹

The University of Massachusetts Medical Center has developed a manual entitled "Establishing Interpreter Services in Health care Settings" [Call 1-800-865-5549 for more information].

Appendix 15 provides the names and contact numbers for directors of interpreter services for Massachusetts acute care hospitals. Contacting your local or neighboring hospitals may provide valuable information on local communities and existing resources. Similarly, local Boards of Health may also be helpful in this regard (Appendix 7).

Medical interpreter training: Refer to Appendix 12 for a list of Massachusetts programs.

Training for providers and staff:

- Boston University School of Medicine has developed a set of videotapes and an accompanying training manual on medical interviewing across language barriers [Available through Boston AHEC at www.umassmed.edu/ocp/programs/ahec.cfm].
- Asian Health Services has a training packet for a 2-3 hour provider education session on medical interpretation that includes a pre-test, post-test, training outline, scripts for three role plays, overhead transparencies for a lecture, and background articles [Call Language Cooperative at Asian Health Services 510-986-6830 for more information].
- CCHCP has developed a three hour workshop for health care providers on how to work with interpreters, and another three hour workshop for health care administrators on the legal, financial, and service aspects of providing care to LEP patients [Available at www.xculture.org/training/overview/interpreter/programs.html].

³⁹ For questions, contact Senior Civil Rights Analyst Deeana Jang at 202-619-1795.

VIII. APPENDICES and WEBSITES

1. MDPH Determination of Need Guidelines
2. Appendix G of the Massachusetts Division of Medical Assistance Acute Hospital RFA Guidelines
3. Chapter 66 of the Acts of 2000, “An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Care Services”
4. MDPH regulations on Chapter 66 of the Acts of 2000
5. Massachusetts Local Boards of Health Addresses
6. Massachusetts Community Interpreter Banks
7. List of organizations that provide telephonic services
8. MDPH Translation Procedure for Written Materials
9. List of organizations that provide translation services
10. Health Care for All ERIL Working Group “Medical Interpreter Trainings – Massachusetts”
11. MMIA Interpreter Code of Ethics
12. List of MA hospital interpreter services directors and contact information
13. Working group members

CLAS Standards available at www.omhrc.gov/clas

DHHS OCR Policy Guidance on Title VI available at www.hhs.gov/ocr

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